North East **LHIN**
RLISS du Nord-Est

North East Local Health Integration Network

Annual Report 2010-2011

... Improving Access to Care in Northeastern Ontario

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

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Cover Photo: **Jackie Blight lives healthy and well in North Bay.**

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North East
Local Health Integration Network

HUB Planning Areas

This illustration depicts the North East LHIN's "HUB" planning areas. Planning areas have been determined by hospital referral patterns within the North East LHIN.

Message from the Board Chair and CEO

This 2010-11 Annual Report highlights the success of our LHIN's work to engage with fellow Northerners and improve access to care in Northeastern Ontario. Over the past year, we have made great strides in advancing local and provincial health care priorities, engaging with hundreds of people on how best to deliver health care in this special part of the province.

The North East LHIN CEO and Interim Chair during an engagement with the Hudson and James Bay Coastal communities.

A few highlights of our achievements include:

- Integrating the provincial James Bay General Hospital and the province's last federal hospital – Weeneebayko Health Ahtuskaywin – into a new Weeneebayko Area Health Authority (WAHA).
- Cutting wait times for knee surgery by 78% with a new North East LHIN Hip and Knee Replacement Program that included five new Joint Assessment Centres in Sudbury, Timmins, Sault Ste. Marie, North Bay and Parry Sound.
- Partnering with our four urban hospitals and the NE CCAC to implement a Home First philosophy so that our seniors and frail elderly can return home quickly and safely with home care support following hospital discharge.
- Engaging on a regular basis with our 21 small rural hospitals, 42 long-term care homes, six community health centres, and many community stakeholders to increase access to care in Northeastern Ontario.
- Holding a Rural Health Summit to bring the leaders of our 25 hospitals and the NE CCAC together to develop innovative solutions to delivering health care to a largely rural and widely dispersed population.
- Working in partnership with the new *Réseau du mieux-être francophone du Nord de l'Ontario* to ensure the needs of Francophones are reflected in local health care planning.
- Leading Ontario's first-ever integrated model of care for addiction and mental health services to bring together 18 providers and 129 services under a new Algoma Anchor Agency.
- Celebrating the official opening of three of our largest urban hospitals –Sudbury Regional Hospital, North Bay Regional Health Centre and the Sault Area Hospital.

As Northeastern Ontario's demographics shift to an aging population, our health care system has to keep pace and ensure programs and services are aligned with the people who live here. This has been the focus of the NE LHIN -- to engage with fellow Northerners and ensure local decision making benefits each one of us.

Peter Vaudry
Interim Chair

Peter Vaudry

Louise Paquette
Chief Executive Officer

Louise Paquette

Welcome to the NE LHIN

Vision and Mission

Health & wellness for all...through an innovative, sustainable and accountable system.

Values

Listen	Our intention: You will be heard.
Integrity	Responsible and accountable for living our values.
Proactive	Anticipate needs and opportunities and act appropriately.
Equity	Opportunity for health and wellness for all.
Serve	Include Northeastern Ontario geographic, cultural, demographic and linguistic health and wellness needs in all activities.

Population and Health Profile

The NE LHIN covers a large geographic area of approximately 400,000 square kilometres. With a 2006 population of 551,691, the overall population density in the NE LHIN is only 1.4 persons per square kilometre. When compared to the provincial population density of 13.4 persons per square kilometre (Southern Ontario has a population density of approximately 100 persons per square kilometre), it is not surprising that there are significant challenges to providing health care in Northeastern Ontario.

The population of the NE LHIN region has decreased slightly by 5%, compared to a provincial growth rate of 13% from 1996 to 2006. Northeastern Ontario is home to a higher population of seniors at 16.5% versus 13.6% provincially. By 2036, the number of seniors living in Northeastern Ontario is expected to increase to 30.6% of the population.

Northeastern Ontario is culturally diverse. Almost one-quarter of the people are Francophone, compared to less than 5% in Ontario. Aboriginal, First Nation and Métis people make up almost 10% of the population, compared to less than 2% across the province.[1]

In order to effectively manage its vast region, the NE LHIN geography is broken down into five HUB areas: Sault Ste. Marie-Algoma, Cochrane-Temiskaming, James Bay and Hudson Bay Coasts, Manitoulin-Parry Sound-Sudbury, and Nipissing. In addition to the population and geographic size differences, there are also demographic variations within HUB planning areas, including:

- The Francophone population varies from 7% in Algoma to approximately 40% in Cochrane-Temiskaming;
- While more than 95% of the James and Hudson Bay Coasts' population is Aboriginal, First Nation or Métis, the proportion of Aboriginal, First Nation or Métis population varies from 8% to 11% in the other HUB areas;
- The proportion of population aged 65 and over varies from approximately 15% in Cochrane-Temiskaming to 19% in Algoma.

Overall, relative to the province, the North East has a higher:

- percentage of the population with Aboriginal identity
- percentage of Francophones
- proportion of older people

- percentage of daily or occasional smokers and exposure to second hand smoke at home
- percentage of adults who are obese or overweight
- prevalence of self-reported activity limitations, arthritis/rheumatism, high blood pressure, diabetes, and asthma[2]
- mortality rates for all causes combined, and for many specific disease categories such as circulatory system diseases, cancer and injuries

... and a lower:

- rate of population growth
- percentage of people with a secondary school certificate or post-secondary education
- percentage of immigrants and visible minorities
- percentage of people with a regular medical doctor or contact with a medical doctor in the last year
- proportion of the population with a family physician which is significantly lower than the provincial average[3]
- percentage of people living in urban communities, and
- percentage of people reporting very good or excellent health.

Statistics such as these play a large role in shaping the delivery of health care and the NE LHIN's mandate to work in partnership with 186 health service providers to plan, fund and integrate local health care.

Population by NE LHIN HUB Area	
Cochrane-Temiskaming	20%
Manitoulin-Parry Sound-Sudbury	43%
Nipissing	17%
Sault Ste. Marie-Algoma	19%
James Bay and Hudson Bay Coasts	1%

The North East LHIN's Aging at Home programs have benefited more than 14,500 seniors.

[1] Statistics Canada 2006 Census
[2] Statistics Canada 2010 Health Profile, Canadian Community Health Survey, 2009
[3] Access to Primary Care in Ontario: 2009; Health Analytics Branch, Health System Information Management and Investment Division September 2010

The North East LHIN works with hundreds of health care providers to ensure local health care programs and services are focused on the needs and priorities of Northerners.

NE LHIN Board of Directors

All Local Health Integration Networks are governed by an appointed Board of Directors. Each Board member is appointed by an Order-in-Council.

The NE LHIN Board has regular open meetings in communities across the region. This allows Directors and staff to meet with the people and health service providers they serve.

Two standing committees report directly to the Board: the Local Aboriginal Health Committee and the Health Professionals Advisory Committee. Two committees, comprised of Board members, also report to the Board: Audit and Governance.

Members of the NE LHIN Board 2010-11

Peter Vaudry, Sault Ste. Marie
Interim Chair
Sault Ste. Marie/Algoma HUB
(May 17, 2006 to May 31, 2008; June 1, 2008 to May 31, 2011)

Randy Kapashesit, Moose Factory
Hudson/James Bay Coasts HUB
(September 20, 2006 to September 19, 2009; September 20, 2009 to September 19, 2012)

Danielle Bélanger-Corbin, Haileybury
Cochrane/Temiskaming HUB
(September 29, 2010 to September 28, 2013)

Byron (Jib) Turner, Manitoulin, North Shore
Sudbury/Manitoulin/Parry Sound HUB
(April 21, 2010 to April 20, 2013)

Dr. Ian Cowan, North Bay
Nipissing HUB
(February 10, 2010 to February 9, 2013)

Leah Welk, Parry Sound
Sudbury/Manitoulin/Parry Sound HUB
(September 24, 2008 to September 23, 2011)

Dr. Colin Germond, Sudbury
Sudbury/Manitoulin/Parry Sound HUB
(April 21, 2010 to April 20, 2013)

Wally Wiwchar, Timmins
Cochrane/Temiskaming HUB
(February 9, 2011 to February 8, 2014)

Ministry-LHIN Performance Agreement (MLPA)

The Ministry-LHIN Performance Agreement (MLPA) defines the relationship between the Ministry of Health and Long-Term Care (MOHLTC) and the NE LHIN in the delivery of local health care programs and services. The MLPA establishes a mutual understanding between the Ministry and the LHIN and outlines performance indicators within a defined period of time.

North East LHIN MLAA Performance Indicators 2010-2011

	Performance Indicator	LHIN 10/11 Starting Point	LHIN 10/11 Performance Target	Most Recent Quarter 2010/11 LHIN Performance	Percent from Target for Most Recent Quarter Result[1]	FY 2010/11 LHIN Annual Result
1	90th Percentile Wait Times for Cancer Surgery (measured in days)	51	48	63	31.3%	62
2	90th Percentile Wait Times for Cardiac By-Pass Procedures (measured in days)	49	49	28	-42.9%	62
3	90th Percentile Wait Times for Cataract Surgery (measured in days)	115	115	141	22.6%	125
4	90th Percentile Wait Times for Hip Replacement (measured in days)	386	300	302	0.7%	301
5	90th Percentile Wait Times for Knee Replacement (measured in days)	382	300	414	38.0%	426
6	90th Percentile Wait Times for Diagnostic MRI Scan (measured in days)	88	69	122	76.8%	105
7	90th Percentile Wait Times for Diagnostic CT Scan (measured in days)	29	29	30	3.4%	33
8	Percentage of Alternate Level of Care (ALC) Days - By LHIN of Institution[3]	27.99%	17.00%	31.05%	82.6%	33.22%
9	90th Percentile ER Length of Stay for Admitted Patients (measured in hours)	21.80	20.70	29.05	40.3%	28.43
10	90th Percentile ER Length of Stay for Non-Admitted Complex (CTAS I-III) Patients (measured in hours)	6.90	6.50	7.88	21.3%	7.20
11	90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated (CTAS IV-V) Patients (measured in hours)	4.30	4.00	4.35	8.7%	4.25
12	Repeat Unplanned Emergency Visits within 30 Days for Mental Health Conditions[2]	16.00%	14.80%	18.99%	28.3%	18.29%
13	Repeat Unplanned Emergency Visits within 30 Days for Substance Abuse Conditions[2]	20.60%	19.00%	29.20%	53.7%	27.30%
14	Readmission to hospital within 30 Days for Selected CMGs[2]	16.60%	14.40%	17.43%	21.0%	16.99%

Notes:

[1] A negative percentage means the LHIN has met its target

[2] FY 2010/11 is based on only 2 quarters of data (Q1-Q2 2010/11) due to availability

[3] FY 2010/11 is based on only 3 quarters of data (Q1-Q3 2010/11) due to availability

Report on MLPA Performance Indicators

Alternate Level of Care (ALC): Throughout the year, the NE LHIN implemented a wide range of initiatives to enhance the flow of patients through the health system: Home First, Assess and Restore beds, Geriatric Emergency Management Nurses, Assisted Living Services, and enhanced service levels for existing residents in assisted living units. These initiatives will contribute to lowering the rate of ALC in the NE LHIN as the NE LHIN's ALC target of 17% was not met in 2010-11. Lack of alternate destinations for patients requiring long-term care remains a significant issue in the NE LHIN. By March 2011, the NE LHIN was beginning to see a reduction in ALC patients occupying hospital beds. It is anticipated that this trend will continue into 2011-12.

Emergency Room Wait Times (ER): The NE LHIN is within target on two of three indicators for ER wait times. The NE LHIN has met its target (within corridor) for two patient groups including those who are identified as high acuity but are not admitted to hospital, and for those who are low acuity and not admitted. Wait times for patients admitted to hospital from the ER increased in 2010-11 due to high numbers of ALC patients occupying acute hospital beds. The impact of this congestion reflects on the time to admission from the ER. Reducing the number of ALC patients in hospital beds will in turn have a positive impact on the wait from the ER to admission to hospital.

Wait Times for Surgery and Diagnostic Imaging

Cancer Surgery: The opening of two new hospital sites in late 2010-11 contributed to delays in cancer surgery.

Cardiac Surgery: By-pass graft surgery wait times increased in the first two quarters of 2010-11 due to the move to a single site at the NE LHIN's lone cardiac surgical centre in Sudbury. Wait times in the third and fourth quarters (Q3 and Q4) returned to below target, and are expected to remain as such.

Cataract Surgery: All cataract surgery hospitals met their wait times volumes but wait times increased in Q3 and Q4 due to demand for surgery. Without additional wait times volumes, hospitals were unable to reduce wait times.

Hip Replacements: The NE LHIN's hip replacement wait time is within target due to the introduction of a Hip and Knee Replacement Centre and Joint Assessment Centres in five centres. All wait time volumes were met in the NE LHIN resulting in acceptance by the Ministry of Health and Long-Term Care of the NE's capacity to repatriate additional surgeries in 2011-12. The implementation of a central registry for joint replacement patients will enable residents to obtain surgeries outside of their home communities and contribute to further wait time reductions.

Knee Replacements: Although the NE LHIN did not meet its target for knee replacements, there was improvement in wait times in Q3 and Q4. A shortage of surgeons and limited patient choice contributed to high wait times for knee replacements. Aggressive recruitment of surgeons in two communities should help to reduce wait times by Q3 in 2011-12.

MRI: Wait times for MRI increased in 2010-11 due to demand. Hospitals achieved their wait time volumes and with additional funding were able to provide more hours of service. An enhanced allocation of wait time hours for 2011-12, and the opening of North Bay's first MRI, will contribute to reduced wait times in 2011-12.

Mental Health/Substance Abuse: Two new MLPA indicators for 2010-11 were reducing repeat unplanned visits to the ER for both mental health and substance abuse concerns. The NE LHIN engaged community health service providers and received feedback on a wide range of initiatives that may assist in reducing these visits to the ER. The NE LHIN is working on a plan to implement initiatives that will fit across the region and expects that unplanned re-visits to the ER will decrease in 2011-12.

Readmission to hospital within 30 Days for Selected Case Mix Groups: Diseases such as congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and diabetes are three examples of chronic illnesses which are amenable to coordinated community care, and can assist in reducing readmissions to hospital. A number of NE LHIN priorities will help address performance on this indicator, in particular the development and implementation of the Ontario Diabetes Strategy. Additionally, enhanced access to primary care (per the 2010 announcement of three new Nurse Practitioner Led Clinics and six new Family Health Teams for the NE LHIN) will help to address a reliance on hospitals in many communities. In addition, evidence-based CHF, COPD and diabetes wound care pathways and ambulatory care clinics are under development in Sudbury.

The North East LHIN funds many programs to support meeting the needs of seniors in the community in which they live. These include meals on wheels, transportation to and from medical appointments, assistance with activities of daily living, services of the North East Community Care Access Centre, and more. Currently, 17% of the population of Northeastern Ontario is age 65 and older. It is estimated that this number will soar to 30% by 2030. The North East LHIN focuses on programs and services that are aligned with the demographics of the region.

Community Engagement

The NE LHIN is accountable and responsive to the public's contributions through the organization's communications and community engagement practices – reflected in the September 2010 Communications and Community Engagement Strategy. In February, 2011, the NE LHIN received the Ministry of Health and Long-term Care Community Engagement Guidelines and Toolkit and worked to ensure all engagement practices are in keeping with the guidelines.

During 2010-11, the NE LHIN built many bridges to enable community engagement: face-to-face meetings, public participation in Board meetings, newsletters and media releases, twitter, facebook, online chat rooms, blogs, and interactive website postings. All information was available in both English and French, and in a plain language style.

The North East LHIN's Community Engagement and Communications Strategy outlines how the input of stakeholders and members of the public is connected to planning and integration efforts.
(Blind River engagement, June 2010)

Northeastern Ontario's cultural diversity was accounted for in community engagement activities. As 24% of our region's residents are Francophone, and 10% are Aboriginal, First Nation or Métis, we held community engagements specifically with members of our Francophone and Aboriginal Communities. (Our engagement activities specific to these groups follow this section.)

Samples of community engagement activities during 2010-11:

- Bimonthly meetings with 21 small rural hospitals
- Quarterly meetings with four hub hospitals and the NE CCAC
- Bimonthly meetings with 42 long-term care homes
- Meeting with five francophone community health centres, December 2010
- Meeting with Chief Administrative Officers of Northeastern Ontario, July 2010
- Rural Health Summit in Sault Ste. Marie, September 2010
- Annual AGM of the Canadian Mental Health Association, Cochrane - Temiskaming CMHA Branch, September 2010, and Sudbury, June 2010
- During Diabetes month (November, 2010), held engagements with: Sudbury Regional Hospital Diabetes Education Program, Timmins Family Health Team, Weeneebayko Health Ahtuskaywin Diabetes Education Program, Temiskaming Diabetes Program and the Northern Diabetes Health Network
- Mental Health Court: Northern Grown Conference in Sault Ste. Marie, November 2010
- More than 25 interactive engagements with the public, including community service groups
- Specific engagements with health service providers such as ALC community steering groups, engagements in keeping with the creation of the Algoma Anchor Agency, meetings with eHealth and Diabetes steering groups, orthopaedic surgeon engagements, and more.

In all, hundreds of Northeastern Ontarians were engaged through a wide variety of means.

Louise Paquette, North East LHIN CEO, and Board Director, Randy Kapashesit, work on the final documents for the creation of the Weeneebayko Area Health Authority (WAHA), further to the integration of Ontario's last federal hospital (Weeneebayko Health Ahtuskaywin) and the provincial James Bay General Hospital (October 1, 2010).

Community Engagement with our Aboriginal/First Nation/Métis People

In 2010-11, the NE LHIN's Local Aboriginal Health Committee (LAHC) held monthly teleconferences and three face-to-face meetings to engage and move forward in partnership with Aboriginal/First Nation/Métis people.

LAHC is a health service provider-driven committee that advises the NE LHIN on health care priorities and opportunities for integration and coordination of services for this important population group.

The NE LHIN regional round table, "Towards Development of a Holistic Framework," hosted six focus groups that were facilitated by research teams throughout the region in North Bay, Sudbury, Timmins, James Bay, Sault Ste. Marie and Wikwemikong.

Throughout the year, the NE LHIN offered training on financial reporting to all First Nation and Aboriginal health service providers both on the Ontario Health Reporting Systems and the Web Enabled Reporting Systems. These sessions were held in Sudbury, Parry Sound, Timmins, and Sault Ste. Marie. Additional information on reporting requirements specific to Aboriginal community health services was held by a regional teleconference in February, 2011.

The NE LHIN met with the following Aboriginal/First Nation/Métis community health service providers over the past year:

- Wikwemikong Chief and Council
- Wikwemikong Nursing Home Board of Directors
- Parry Sound Health Fair Planning Session
- Moosonee Clinic on the Aging at Home Strategy
- Moose Factory First Nations, meeting with Chief and CEO and Health Services Home Support Program
- Fort Albany Chief and Council Meeting
- Wasauksing First Nations
- Ontario MD Emergency Medical Records Conference, Sudbury Presentation by the NE LHIN regarding Aboriginal Engagement and NE LHIN's Aboriginal Health Services funding breakdown
- North Shore Tribal Council Chiefs
- Mushkegowuk Tribal Council Health Summit
- Giiwednong Health Link meeting
- Chapleau First Nations
- Shawanaga First Nations-Parry Sound
- James & Hudson Bay Coastal Aboriginal Primary Care Strategy
- Northern Ontario Rural Summit - NE LHIN Aboriginal health service provider presentation
- Aboriginal Peoples Alliance of Northern Ontario
- Ontario Hospital Association - Aboriginal health and Intergenerational Relationship presentation
- N'Swakamok Indian Friendship Centre
- M'Chigeeng First Nations Health Services
- North Shore Tribal Council - Community Support Service - Common Assessment Project

Sweat Lodge - part of the the Weeneebayko Area Health Authority traditional health program.

Community Engagement with our Francophone Population

On June 29, 2010, the Réseau du mieux-être francophone du Nord de l'Ontario was named as the new French Language Health Planning Entity for the North East and North West LHINs. On March 14, 2011, the NE LHIN and the NW LHIN signed a historic, five-year agreement with the Réseau du mieux-être francophone du Nord de l'Ontario.

The agreement clearly outlines how the planning entity will provide each LHIN with guidance on engaging the local Francophone communities, determining their health needs and priorities, identifying Francophone health services and health care providers, and improving access to French language health services.

In 2011-12, the NE LHIN and the Entity will collaborate on a community engagement process to ensure that the region's 125,000 Francophones are engaged on health care priorities.

In December 2010, the NE LHIN CEO and French Language Services staff met with five bilingual and Francophone Community Health Centres (CHC) to present an overall view of LHIN-funded health services in the North East. The community health centre sector was provided with an opportunity to share information specific to their communities, and the challenges and opportunities in primary care. This engagement activity led to the development of an action plan to be implemented by the NE LHIN and the CHC sector in 2011-12.

The NE LHIN's French Language Service Coordinators also contributed to continued community engagement by representing the NE LHIN in several Francophone communities.

Jacqueline Gauthier, Executive Director of the Sudbury East Community Health Centre speaks at a March 2011 media event which announced a new bilingual electronic medical record (EMR). The EMR will be used by 2,500 health care providers across the province, including 100 community health centres. The North East LHIN is home to six community health centres.

Providing local health care programs and services to a largely dispersed population of 550,000 is possible with the NE LHIN's increase in community-based services and expansion of telemedicine programs.

Integrated Health Service Plan (IHSP) - Meeting Local and Provincial Priorities

The IHSP is the LHIN's strategic plan that guides the actions, programs and projects over a three-year period. The NE LHIN published its first IHSP in December 2006, and a second plan in November 2009 for the 2010-2013 time period. The nine priorities outlined in the current IHSP are interrelated. The priorities are regionally focused; however, their management is important to the rising tide of improved health services across the province. The implementation of these priorities will be approached through innovations in information and communication technology and electronic processes (eHealth).

The NE LHIN priorities identified in our current IHSP can be grouped as follows:

(1) Alternate Level of Care Strategies and Solutions

- *Emergency Department Wait Times*
- *Aging at Home*

(2) An Integrated Approach to Cultural Diversity

- *Aboriginal/First Nation/Métis Health Services*
- *French Language Health Services*

(3) Addiction and Mental Health Services

Developing a more integrated system to help address addiction and mental health needs of individuals and communities across the region

(4) Diabetes Care

Identifying and planning local diabetes initiatives that support the goal of self-management for those people living with diabetes in Northeastern Ontario

(5) Health Human Resource

Engaging with local health service providers, communities and individuals to determine innovative ways to use our current workforce and attract and retain additional professionals for Northeastern Ontario

(6) Optimize Surgical Services

Ensuring equitable access to surgical services across the region

Integration and eHealth are processes of change necessary for a more patient-focused and efficient health system of care. The NE LHIN eHealth team relies on our exceptional health service providers for guidance and leadership to help build a comprehensive electronic health record (EHR) by 2015.

In 2010-2011, providers were actively engaged and leading many initiatives such as Doorways, Physician Office Integration and Network Managed Services. As well, the NE LHIN provided telemedicine equipment upgrades; established a Nurse Peer eHealth Network; coordinated an EMR vendor conference with OntarioMD; developed a collaboration site for hospitals and incorporated the results from an online survey and consultation sessions to develop a refreshed eHealth strategic plan which provides the tactical plan of our eHealth roadmap.

Alternate Level of Care Strategies and Solutions (ALC)

ALC patients are people in hospital beds who would be better cared for in an alternate setting, such as long-term care, rehabilitation, or home. Having more home care and community services enables ALC patients to leave hospital sooner, making more beds available to patients who are waiting to be admitted to hospital. In recent years, the NE LHIN had the highest level of ALC in the province.

Louise Paquette, CEO, chats with Elizabeth Gorky, a Finlandia Village resident, at an Aging at Home event in August 2010.

The NE LHIN has maintained that no one organization or individual will solve the long-standing and complex issue of ALC. In 2010-11, the NE LHIN continued to work in partnership with health service providers and community leaders with the collective goal of fewer ALC patients in our hospital beds, seniors receiving the care they need in the most appropriate setting, and more home care services.

The NE LHIN has been active in bringing together local partners in Sault Ste. Marie, Sudbury, Parry Sound, North Bay/Nipissing district and Timmins/Cochrane. ALC pressures in these areas collectively account for 70% of the issue in the region. After a number of strategies were put in place in the four largest district hospital centres, the number of ALC patients in acute care beds dropped since August 2010 by half, to an average of 13 per cent.

A range of strategies were implemented or enhanced in 2010-11, including:

- expanding the North East Specialized Geriatric Services
- initiating Home First / Integrated Discharge Planning in the four HUB hospital communities
- new Assess / Restore programs in Sault Ste. Marie and Sudbury
- geriatric emergency management nurses and CCAC case managers in EDs
- transitional care capacity to safeguard acute care services
- new permanent and interim long-term care home capacity
- additional seniors' assisted living capacity and enhanced CCAC in-home services.

These initiatives are having a positive impact. Nonetheless, both North East and provincial ALC-related studies completed during 2010-11 indicate that there is much work remaining, particularly to address the needs of individuals with behavioural issues who remain in hospital as there is no alternative available for them in the community. Work to put in place programs for this group of individuals is a priority for the NE LHIN in the coming year.

Emergency Department (ED) Wait Times

Throughout 2010-11, ED wait times in the North East, for both non-admitted complex and non-admitted minor/uncomplicated ED cases was at or near the LHIN's target for these indicators (i.e. 90% of cases discharged within 6.5 and 4 hours respectively). The challenge in some communities remains the wait time for admitted patients due to the level of ALC patients occupying acute care beds. The region's four large hospitals participated in the provincial ED Pay for Results program in 2010-11 which helped them implement innovative programs targeted at improving ED performance, such as geriatric nurses in the ED, electronic tracking system in the ED, and more.

Aging at Home

The NE LHIN has invested $18.5 million over three years in Aging at Home strategies across Northeastern Ontario. In 2010-11, the third year of the strategy, the NE LHIN allocated $7.8 million to further support caring for the frail and elderly.

Art Pyette, who lives independently as a resident at Finlandia Village in Sudbury, speaks at an Aging at Home event and highlights the value of assisted living services.

Aging at Home initiatives are helping to reduce community ALC pressures and unnecessary emergency room visits by seniors through solutions such as more home care support programs (e.g. personal hygiene and meal preparation), assisted living services, community-based services (e.g. help with transportation), additional long-term care home spaces and the new Home First philosophy in the region's four large communities.

Specifically 2010-11 Aging at Home funding focused on:

1. New and redeveloped long-term care home beds and additional transitional bed capacity (i.e. interim long-term care beds and assess / restore beds)
2. Outreach teams (i.e. seniors' assisted living services)
3. Aboriginal/First Nation/Métis community service enhancement and discharge planning programs
4. Expanding the North East Regional Specialized Geriatric Services
5. Home First – Working in partnership with the NE CCAC to implement a Home First philosophy in the region's four urban hospitals.

Aboriginal/First Nation/Métis Health Services

A milestone integration came to fruition on October 1, 2010 with the integration of the federal Weeneebayko Health Ahtuskaywin and the provincial James Bay General Hospital into the Weeneebayko Area Health Authority (WAHA).

In 2010-11, the Local Aboriginal Health Committee focused on two significant activities:

(1) The Aboriginal/First Nation/Métis Health Status and Environmental Scan provides the NE LHIN with an inventory of health information, services and research partners who can be engaged to begin the process of updating and correcting the required health information deficits in evidence-based Aboriginal information. It outlines how the health needs of Aboriginal communities across the NE Region are significant in magnitude, including:

- High rates of type 2 diabetes
- Prevalence of Tuberculosis
- High instances of infant mortality
- More high risk and teen pregnancies
- High suicide rates - Suicide and self-injury of Aboriginal youth accounted for 38 per cent of deaths among youth, and 23 per cent among adults aged 20-44
- Health Canada reported that in 2000, Aboriginal males were expected to live eight years less than the general population, and 5.5 years less for females.
- The mortality rate in Northern Ontario is 18% higher relative to Ontario as a whole (7.4 vs. 6.3 deaths per 1000)
- Injuries severe enough to require a hospital admission were higher in First Nations communities in northern Ontario relative to those in northern and southern Ontario communities, underscoring the importance of using a geographic comparison group

NE LHIN CEO Louise Paquette visits with Dawn Madahbee.

(2) The Aboriginal/First Nation/Métis Mental Health and Addictions Research was completed in the fall of 2010. It identified priorities that led to the development of a mental health and addictions framework. This strategy will align the provincial and federal programs to better meet the needs of Aboriginal people in Northeastern Ontario.

Given that specialized intensive tertiary services are only available within the mainstream health system at this time, this significant research will help to identify the services required to develop a comprehensive continuum of care in Aboriginal communities across the region.

French Language Health Services – An Integrated Approach

Over the last year, the NE LHIN has made significant progress in its priority of improving the integration of French Language Services within the local health care system.

In late summer 2010, three French Language Service (FLS) Coordinators joined the NE LHIN. Along with a Senior Director, the FLS team was instrumental in implementing the FLS Act into the local health care system. For example, the NE LHIN supported two health service providers – Nipissing Mental Health Housing and Support Services, and the Hôpital régional de Sudbury Regional Hospital with FLS designation plans. These plans were approved by the NE LHIN's Board and submitted to the Ministry of Health and Long-Term Care for final approval.

Northeastern Ontario is home to 125,000 Francophones. Improving access to care in the official language of choice is a priority of the NE LHIN. (Fabien Hébert CEO of Smooth Rock Falls Hospital, and NE LHIN CEO Louise Paquette.)

The FLS team developed a quality assurance plan that included a revision of internal processes for the implementation of FLS in practices, policies and procedures, a revised page on the NE LHIN website, and an education session for health service providers on FLS matters.

The NE LHIN also provided its health service providers with educational opportunities in French on the preparation of required planning submissions, inclusion of FLS performance indicators in accountability agreements, and e-Health issues.

With the April 2011 amalgamation of North Bay General Hospital and the Northeast Mental Health Centre, the NE LHIN supports a close working relationship with the newly established joint French Language Services (FLS) Committee of the North Bay Regional Health Centre to develop FLS policies and procedures that will lead to the development of a FLS designation in 2013.

In order to monitor continuous improvement in the quality, accessibility and integration of FLS at the Health Service Provider level, the NE LHIN successfully included and negotiated a FLS performance indicator in the 2010-2013 long-term care service accountability agreements, the 2011-2014 multi-sectoral service accountability agreement and the 2011-2012 hospital service accountability agreement with 115 HSPs identified to deliver FLS in the North East LHIN region.

Addiction and Mental Health Services

As a result of a recommendation from the Regional Advisory Committee to the NE LHIN, the NE LHIN board supported the recommendation to relocate 31 adult specialized tertiary beds from the North East Mental Health Centre (NEMHC) in North Bay to the Kirkwood site in Sudbury. This move paved the way for NEMHC to move into its new hospital location in North Bay in January 2011. The new unit at the Kirkwood site opened in early January 2011.

In order to meet the demand for adult acute mental health services in Algoma, the NE LHIN board passed an integration order which allowed Sault Area Hospital to open an additional seven beds to the footprint of the new hospital site. This decision allowed the hospital to maintain its current level of 30 beds. In March 2010, the NE LHIN board accepted a report from the Algoma Health System Round Table to integrate addictions and mental health services in that district. Following consultation and analysis, the NE LHIN board approved the establishment of an Algoma integrated addiction and mental health "Anchor Agency." A project team of various professionals was established to oversee this project and in March 2011 the project manager was hired. The planning for this project is ongoing.

During 2010, mental health agencies in the NE LHIN continued their work to implement the Ontario Common Assessment of Need (OCAN). This tool provides a standardized approach to identifying the needs of consumers across the service sector. Addictions and Mental Health services were also provided LHIN-funded training on the GAIN short screening tool.

The NE LHIN also worked with addictions and mental health providers to implement a project that when completed will have 72 subsidized housing opportunities for chronically addicted individuals without housing. The goal of the program is to provide supports to these individuals in an effort to reduce numerous repetitive hospital visits and or readmission.

Diabetes Strategy

As a member of the Diabetes Regional Coordination Centre, the NE LHIN works with service providers to determine service needs and gaps, identify strategies, and provide tools and resources to support integration of best practices.

The NE LHIN continued its efforts to implement the Ontario Diabetes Strategy.

The prevalence of diabetes in Northeastern Ontario is higher than the provincial average. Active lifestyles contribute to healthier individuals, young or old.

Through the work of the Diabetes Management Steering Committee, the NE LHIN identified diabetes team expansions in Cochrane and Blind River.

As a result of a $25,000 NE LHIN investment in 2010 and the purchase of three OTN desktops, individuals residing in rural areas have access to an endocrinologist as part of their continuing diabetes treatment. In the first year alone, 252 additional follow-up visits via OTN were offered to individuals with diabetes. Future plans include having a pharmacist provide tele-pharmacy consultation via OTN to rural patients and diabetes teams where medications are a large part of the diabetes treatment, maximizing adherence to medication and patient outcome.

Through a call for proposals, the NE LHIN identified and recommended the Sudbury Regional Hospital as the Self-Management Lead for Northeastern Ontario. The one-time fund of $91,500 provided to the hospital will help improve the lives of people living with diabetes or at risk of developing diabetes.

In the summer of 2010, the NE LHIN participated in the MOHLTC Stand-Up to Diabetes presentation in Sudbury and North Bay and helped to launch the new MOHTLC diabetes information website.

Health Human Resources

The NE LHIN's Health Human Resources (HHR) Planning Steering Committee leads HHR planning efforts and ensures they are aligned with local HHR issues.

A broad definition of the scope of HHR is being used at this stage of the NE LHIN's planning efforts. The scope includes areas such as recruitment and retention, partnerships and collaboration, training and development, and occupational health and safety. Planning is inclusive of all HHR including leadership, physicians and other professionals, staff, students and volunteers.

The NE LHIN's Healthcare Workforce Inventory Snapshot Tool was successfully launched in the fall of 2010 with approximately 50 per cent of programs/services participating. The tool is a web-based application that can be updated by participating providers. A quarterly snapshot of the region's healthcare workforce can now be produced to monitor movement in the numbers, and to inform collaborative planning discussions.

A workforce demand forecasting tool was implemented within a small group of providers. Seven organizations completed a year-long pilot initiative. The application of the forecasting methodology is allowing providers to anticipate the need for human resources by including staff characteristics, staffing changes, percentage of novice staff, occupancy, sick time, and overtime.

The NE LHIN established a working group to develop an action plan in response to the recommendations of the 2010 Report on Personal Support Occupations (PSO) in the North East. *"Enhancing the PSO Workforce"* offers strategies to address health human resources issues through: 1) increased promotion and recruitment; 2) better access to education and training; and 3) improved working conditions and retention of the workforce.

Optimize Surgical Services

The NE LHIN moved forward with the key recommendations from the *North East Surgical Optimization Report, May 2009*. The key priorities addressed in 2010-11 were:

Hip and Knees

The North East Hip and Knee Replacement Program (NE HKRP) was implemented across the North East. The NE HKRP model includes five Joint Assessment Centre (JAC) sites: Hôpital régional de Sudbury Regional Hospital (HRSRH), North Bay Regional Health Centre (NBRHC), Sault Area Hospital (SAH), Timmins and District Hospital (TDH), and West Parry Sound Health Centre (WPSHC).

The model helps reduce wait times for hip and knee surgery and allows patients to remain in the North East for their surgery. It also offers patients options to choose the care they need. A NE HKRP Coordinator was hired to coordinate the activities of the NE HKRP. A web-based referral and tracking system is being developed for the NE HKRP. This will allow all the NE JACs to coordinate referrals and collect the required data for the NE HKRP.

An engagement session with the North East LHIN's orthopaedic surgeons on how best to implement a regional hip and knee replacement program. The North East LHIN witnessed early success with the program which was implemented in 2010 and allowed for a substantial decrease in wait times for hip and knee surgery.

Vascular Surgery

Vascular Surgeons from the two hospitals in the North East offering vascular services (Sault Area Hospital and Hôpital régional de Sudbury Regional Hospital) met to discuss the distribution of Endovascular Aneurysm Repair (EVAR) services. A report detailing the outcome of the meeting was prepared and reviewed by the Surgical Optimization Steering Committee. The vascular surgeons agreed to maintain status quo in the distribution of the vascular surgery in the North East and to have the EVAR procedures remain at Hôpital régional de Sudbury Regional Hospital.

Call Schedule Project

Dr. Isser Dubinsky, Project Lead, and Dr. Tim Zmijowskyj, Project Associate, were hired by the NE LHIN to work on the call schedule project. The goal of the project is to identify opportunities to streamline access to urgent and emergency surgical care as it relates to Ophthalmology, Orthopaedic, Otolaryngology, Plastics, Urology, and General Surgery. The project will also consider whether hospitals that lack some surgical specialties could develop formal relationships with nearby NE LHIN hospitals and establish referral networks.

The first phase of work is almost complete. Project team members have contacted several of the NE LHIN hospitals and physicians to gather additional information and schedule interviews for input on the process.

Meetings with the specialty groups are nearing completion. Participation in the project by the specialists has been very strong. Work on the second phase of the project has commenced. This includes the development of a framework for a North East call coverage model.

Dr. Zmijowskyj – Co-lead of the NE LHIN's Call Schedule Project which is aimed at streamlining access to urgent and emergency surgical care.

NE LHIN Integration Activities

The NE LHIN's Integration Strategy details how the NE LHIN encourages and supports integrations that:

- enhance access to, and quality of, health services;
- improve individual and population health outcomes;
- improve the overall patient experience within the health system by reducing gaps and duplications; and
- realize greater efficiencies through the most effective use of available resources.

In 2010-2011, the NE LHIN continued to support health service providers who voluntarily integrated services or programs to streamline the local health care system. This approach ensures a more patient-focused and integrated system of care. Highlights of integration work in the past year include:

Weeneebayko Area Health Authority (WAHA)

On October 1, 2010, the last federally-funded hospital in Ontario (Weeneebayko Health Ahtuskaywin) and the provincial James Bay General Hospital integrated into one new health authority – WAHA. WAHA serves 11,500 people living along the Hudson and James Bay Coasts and is working to improve access to care for the region's most Northerly citizens.

Sheguiandah First Nation and Mnaamodzawin First Nation

These two First Nations integrated administrative services to ensure that the existing health care services delivered to members of the Sheguiandah First Nation would be maintained, sustained and delivered in a coordinated manner.

North Bay General Hospital (NBGH) and Northeast Mental Health Centre (NEMHC)

On January 30, 2011, both the North Bay General Hospital and the Northeast Mental Health Centre moved to one new site. On March 31, 2011, both hospitals ceased to exist as separate entities and integrated into the North Bay Regional Health Centre.

Integration of the Sault Area Hospital Rehab Program into the Sault Ste. Marie March of Dimes Trauma Rehab Program

In February 2011, the Sault Area Hospital agreed to transfer the outpatient trauma rehabilitation services to the Ontario March of Dimes. This will facilitate successful community re-entry for patients with functional disabilities as a result of physical trauma and reduce the duplication of service in Sault Ste. Marie as both providers were offering this service.

Algoma Anchor Agency

In 2010, the NE LHIN Board supported the process to integrate 18 mental health and addiction providers and 129 services into an Algoma Anchor Agency. This integration will streamline mental health and addiction services for people in Algoma. Work continues on this integration with the goal of having a new Board in place by the fall of 2011.

Acute Mental Health Services in Algoma

In order to meet the demand for adult acute mental health services in Algoma, the NE LHIN board passed an integration order which allowed Sault Area Hospital to open an additional seven beds to the footprint of the new hospital site. This decision allowed the hospital to maintain its current level of 30 beds.

Consolidation of Multi Sector Accountability Agreements (MSAA)

Through proactive integration efforts, the NE LHIN decreased the number of MSSAs it held with community health service providers from 135 to 119. For the first time, one service agreement was negotiated amongst four providers who offer services in various communities across the North East – the local chapters of the Canadian National Institute for the Blind, Red Cross, VON, and the Canadian Hearing Society.

Analysis of LHIN Operational Performance

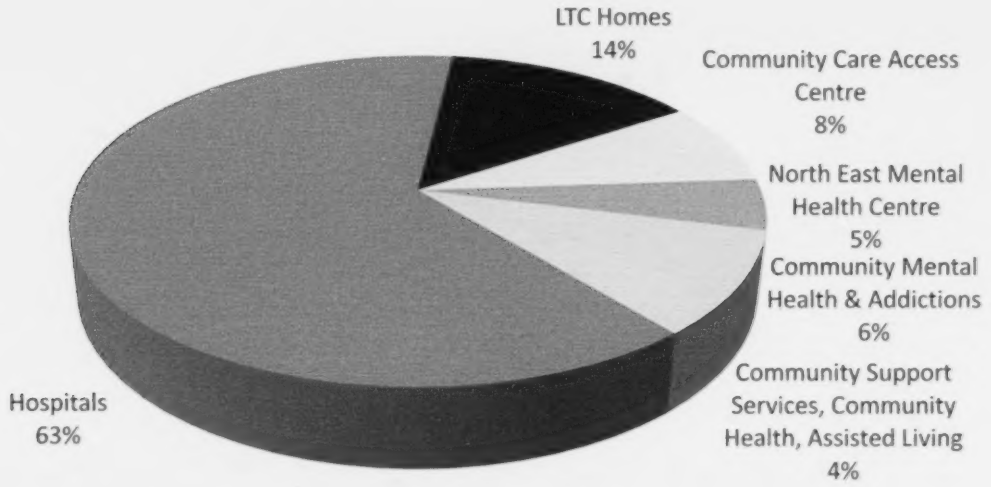
The NE LHIN managed its responsibilities with a balanced budget in 2010-11. With a region that spans 400,000 square kilometres and is home to more than 555,000 people, the NE LHIN has established satellite offices in Sudbury, Sault Ste Marie and Timmins. Establishing HUB areas will allow the staff of the NE LHIN to have more direct contact with health service providers (HSPs) while encouraging HSPs to work together for better patient care delivery within each HUB.

Our NE LHIN complement increased in 2010-11 to 36 full time staff due to the transfer of three French Language Services staff to our LHIN. These staff will provide valuable insight into improving the health status of the Francophone population.

We have established an Alternate Level of Care Lead in our LHIN to focus on our top priority - to reduce ALC patients.

The skills of our staff were used to negotiate 135 accountability agreements this year with the community and hospital sector, participate in community engagement sessions, and to provide current communication and education sessions to the region.

In 2010-2011, the North East LHIN invested $1.3 billion dollars in local health care programs and services.



Financial statements of

North East Local Health Integration Network

March 31, 2011

North East Local Health Integration Network

March 31, 2011

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Independent Auditor's Report

To the Members of the Board of Directors of the
North East Local Health Integration Network

We have audited the accompanying financial statements of the North East Local Health Integration Network (the "LHIN"), which comprise the statement of financial position as at March 31, 2011, and the statements of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion
In our opinion, the financial statements present fairly, in all material respects, the financial position of LHIN as at March 31, 2011, and the results of its financial activities, change in its net debt and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 31, 2011

North East Local Health Integration Network

Statement of financial position
as at March 31, 2011

	2011	2010
	$	$
Financial assets		
Cash	**813,944**	698,735
Due from the LHIN Shared Services Office (Note 3)	**1,632**	4,969
Accounts receivable	**67,719**	-
HST Receivable	**109,806**	-
Due from MOHLTC-Other	**-**	235,000
Due from MOHLTC-Health Service Providers ("HSP")	**20,697,997**	4,113,341
	21,691,098	5,052,045
Liabilities		
Accounts payable and accrued liabilities	**633,563**	641,712
Due to MOHLTC (10b)	**360,216**	296,992
Due to Health Service Providers ("HSP")	**20,697,997**	4,113,341
Deferred capital contributions (Note 4)	**226,144**	215,190
	21,917,920	5,267,235
Net debt	**(226,822)**	(215,190)
Non-financial assets		
Prepaid expenses	**678**	-
Capital assets (Note 5)	**226,144**	215,190
	226,822	215,190
Accumulated surplus	**-**	-

Approved by the Board

Peter Vaudry Director

Director

North East Local Health Integration Network

Statement of financial activities
year ended March 31, 2011

	Budget (unaudited) (Note 6)	2011 Actual	2010 Actual
	$	$	$
Revenues			
MOHLTC funding			
HSP transfer payments (Note 7)	**1,221,145,343**	**1,334,539,486**	1,240,203,544
Operations of LHIN	**4,928,982**	**4,919,443**	4,684,155
e-Health (Note 9a)	**600,000**	**600,000**	600,000
e-Health Project Funding (Note 9b)	**110,000**	**110,000**	200,000
French Language Health Service (Note 9c)	**186,400**	**209,900**	-
Francophone Community Engagement (Note 9d)	-	**186,400**	-
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9e)	-	**229,040**	-
Emergency Department Lead (Note 9f)	-	**75,000**	60,000
Critical Care Lead (Note 9g)	-	**75,000**	-
Aboriginal Engagement (Note 9h)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund (Note 9i)	**146,590**	**146,590**	238,874
Emergency Room/Alternate Level of Care (Note 9j)	-	**100,000**	100,000
Diabetes Strategy	-	-	65,000
Diabetes: Self-Management	-	-	35,000
Amortization of deferred capital contributions (Note 4)	**53,250**	**72,485**	243,602
	1,227,270,565	**1,341,363,344**	1,246,530,175
Expenses			
Transfer payments to HSPs (Note 7)	**1,221,145,343**	**1,334,539,486**	1,240,203,544
General and administrative (Note 8)	**4,928,982**	**4,706,974**	4,679,829
e-Health (Note 9a)	**600,000**	**600,000**	596,734
e-Health Project Funding (Note 9b)	**110,000**	**76,977**	200,000
French Language Health Service (Note 9c)	**186,400**	**171,738**	-
Francophone Community Engagement (Note 9d)	-	**118,681**	-
Réseau du mieux-être francophone du Nord de l'Ontario (Note 9e)	-	**229,040**	-
Emergency Department Lead (Note 9f)	-	**69,000**	60,000
Critical Care Lead (Note 9g)	-	**72,157**	-
Aboriginal Engagement (Note 9h)	**100,000**	**100,000**	100,000
Aboriginal Health Transfer Fund (Note 9i)	**146,590**	**146,590**	58,632
Emergency Room/Alternate Level of Care (Note 9j)	-	**100,000**	100,000
Diabetes Strategy	-	-	65,000
Diabetes: Self-Management	-	-	8,800
Amortization of capital assets	**53,250**	**72,485**	243,602
	1,227,270,565	**1,341,003,128**	1,246,316,141
Annual surplus before repayable to MOHLTC	-	**360,216**	214,034
Funding repayable to MOHLTC (Note 10a)	-	**(360,216)**	(214,034)
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing accumulated surplus	-	-	-

North East Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2011

	2011	2010
	$	$
Annual surplus		
Acquisition of tangible capital assets	**(83,439)**	(244,826)
Amortization of tangible capital assets	**72,485**	243,602
Increase in prepaid expenses	**(678)**	-
Increase in net debt	**(11,632)**	(1,224)
Opening net debt	**(215,190)**	(213,966)
Closing net debt	**(226,822)**	(215,190)

North East Local Health Integration Network

Statement of cash flows
year ended March 31, 2011

	2011	2010
	$	$
Operating transactions		
Annual surplus	-	-
Items not affecting cash		
Amortization of capital assets	**72,485**	243,602
Amortization of deferred capital contributions (Note 4)	**(72,485)**	(243,602)
Changes in non-cash working capital		
Decrease (Increase) in due to/from the LHIN Shared Services Office	**3,337**	(27,073)
Increase in accounts receivable	**(67,719)**	-
Increase in HST Receivable	**(109,806)**	-
Decrease (Increase) in due from MOHLTC-Other	**235,000**	(235,000)
Increase in due from MOHLTC-Health Service Providers	**(16,584,656)**	(411,741)
Increase in Prepaid expenses	**(678)**	-
Decrease in accounts payable and accrued liabilities	**(8,149)**	(176,237)
Increase in due to MOHLTC	**63,224**	168,660
Increase in due to Health Service Providers	**16,584,656**	411,741
	115,209	(269,650)
Capital transactions		
Acquisition of capital assets	**(83,439)**	(244,826)
Financing transactions		
Increase in deferred capital contributions (Note 4)	**83,439**	244,826
Net increase (decrease) in cash	**115,209**	(269,650)
Cash, beginning of year	**698,735**	968,385
Cash, end of year	**813,944**	698,735

1. Description of business

The North East Local Health Integration Network was incorporated by Letters Patent on June 9, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the *Local Health System Integration Act, 2006* (the "Act") as the North East Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and Long Term Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2011.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the area of Northeastern Ontario. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of tangible assets and losses in the value of assets.

2. Significant accounting policies (continued)

Ministry of Health and Long-Term Care Funding

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as tangible capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the statement of financial activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed tangible capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the tangible capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method

For assets acquired and brought into use during the year, amortization is provided for a full year.

2. Significant accounting policies (continued)

Segment disclosures

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the statement of financial activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the LHIN Collaborative (LHINC) are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs, are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portions of the LSSO/LHINC operating costs overpaid (or not paid) by the LHIN at the year end are recorded as a receivable from (payable to) the LSSO/LHINC. This is all done pursuant to the agreement the LSSO/LHINC has with all the LHINs.

4. Deferred capital contributions

	2011	2010
	$	$
Balance, beginning of year	**215,190**	213,966
Capital contributions received	**83,439**	244,826
Amortization	**(72,485)**	(243,602)
Balance, end of year	**226,144**	215,190

5. Capital assets

			2011	2009
	Cost	**Accumulated amortization**	**Net book value**	Net book value
	$	**$**	**$**	$
Furniture and fixtures	**134,743**	**83,272**	**51,471**	5,398
Computer equipment	**96,622**	**95,344**	**1,278**	8,965
Leasehold improvements	**985,125**	**811,730**	**173,395**	200,827
	1,216,490	**990,346**	**226,144**	215,190

6. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the statement of financial activities reflect the initial budget at April 1, 2010. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $1,334,539,486 is made up of the following:

	$
Initial HSP Funding budget	**1,221,145,343**
Adjustment due to announcements made during the year	**113,394,143**
Total HSP Funding budget	**1,334,539,486**

The total operating budget of $6,834,812 is made up of the following:

	$
Initial budget	**6,071,972**
Additional funding received during the year	**762,840**
Total budget	**6,834,812**

7. Transfer payments to HSPs

The LHIN has authorization to allocate the funding of $1,334,539,486 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2011	2010
	$	$
Operation of Hospitals	**865,514,596**	787,852,105
Grants to compensate for Municipal Taxation - Public Hospitals	**211,950**	254,475
Long Term Care Homes	**182,523,879**	177,584,058
Community Care Access Centres	**106,197,563**	100,772,313
Community Support Services	**25,190,467**	23,232,856
Acquired Brain Injury	**2,170,491**	1,741,573
Assisted Living Services in Supportive Housing	**11,098,349**	9,908,082
Community Health Centres	**15,775,767**	14,053,035
Community Mental Health	**49,947,087**	48,266,691
Substance Abuse & Problem Gambing	**20,440,417**	19,576,342
Specialty Psychiatric Hospitals	**55,448,895**	56,946,864
Grants to compensate for Municipal Taxation - Psychiatric Hospitals	**20,025**	15,150
	1,334,539,486	1,240,203,544

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2011, an amount of $20,697,997 (2010 - $4,113,341) was receivable from the MOHLTC and was payable to the HSPs. These amounts have been reflected as revenue and expenses in the statement of financial activities and are included in the table above.

8. General and administrative expenses

The statement of financial activities presents the expenses by function; the following classifies these same expenses by object:

	2011	2010
	$	$
Salaries and wages	**2,671,788**	2,421,825
HOOPP	**252,040**	222,485
Other benefits	**279,041**	275,298
Staff travel	**190,375**	193,788
Governance travel	**55,156**	83,021
Communications	**93,224**	76,374
Accommodation	**171,625**	161,681
Advertising	**18,092**	10,241
Banking	**5**	5
Consulting fees	**67,270**	234,161
Equipment rentals	**16,085**	17,236
Board Chair per diems	**68,738**	67,008
Other Governance per diems	**29,532**	52,898
Insurance	**17,307**	15,930
LHIN Shared Services Office	**409,495**	362,715
LHIN Collaborative	**50,000**	12,285
Other meeting expenses	**36,987**	31,526
Other governance expenses	**40,991**	78,082
Printing and translation	**68,855**	56,312
Staff development	**20,778**	71,084
IT equipment	**40,544**	73,408
Office supplies and equipment	**59,254**	68,558
Other	**49,792**	93,908
	4,706,974	4,679,829

9. a) e-Health expense

The e-Health office of the Ministry of Health and Long-Term Care provided $600,000 to the LHIN. The LHIN has four permanent full-time staff to run a Project Management Office related to e-Health. In addition to covering the staff costs, the LHIN also incurred costs related to projects this group is responsible for. The total amount of expenses the LHIN incurred related to e-Health was $600,000.

b) e-Health Project Funding

The e-Health office of the Ministry of Health and Long-Term Care provided $110,000 to the LHIN related to the Implementation and Adoption Readiness project. In 2010/11 the LHIN incurred expenses of $76,977 related to this project.

c) French Language Health Services (FLHS)

The LHIN received $209,900 ($12,000 one-time, $197,900 pro-rated base) from the Ministry of Health and Long-Term care to support the start-up and implementation of the French Language Health Services program. With these funds the LHIN hired three full-time staff to work on this file. The total amount of expenses incurred related to FLHS was $171,738.

9. d) **Francophone Community Engagement**

The Ministry of Health and Long-Term Care in 2009/10 announced one-time funding of $186,400 so support Francophone Community Engagement activities. The LHIN made a formal request to have these funds moved into 2010/11 and the carry forward was granted. A contract was entered with Smooth Rock Falls Hospital to complete this engagement, the total value of the contract was $186,400. Actual funds spent were $118,681, resulting in a surplus of $67,719.

e) **Réseau du mieux-être francophone du Nord de l'Ontario**

The LHIN received $229,040 ($30,000 one-time, $199,040 pro-rated base) from the Ministry of Health and Long-Term Care to fund the start-up and operation of the Réseau du mieux-être francophone du Nord l'Ontario for the period of January 1, 2011 – March 31, 2011. Total funds flowed in 2010/11 were $229,040.

f) **Emergency Department Lead (ED Lead)**

The Ministry of Health and Long Term Care announced they would be providing the LHIN an additional $75,000 in one-time funding to (a) pay the LHIN ED Lead $6,000 per month as well as (b) money to reimburse the LHIN ED Lead for any expenses. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2010/11 are $69,000.

g) **Critical Care Lead (CC Lead)**

The Ministry of Health and Long Term Care announced they would be providing the LHIN an additional $75,000 in one-time funding to (a) pay the LHIN CC Lead $6,000 per month as well as (b) money to reimburse the LHIN ED Lead for any expenses. The LHIN contracted an area physician as the ED Lead; total monies paid out in 2010/11 are $72,157.

h) **Aboriginal Engagement**

The Ministry of Health and Long Term Care provided an additional $100,000 in base funding for the purposes of engaging the Aboriginal population and organizations with the North East LHIN. The total amount of expenses paid using this funding was $100,000.

i) **Aboriginal Health Transfer Funding (AHTF)**

A formal request to have $146,590 from 2009/10 carried forward into 2010/11 was approved by the Ministry of Health and Long Term Care. Total expenses incurred during 2010/11 related to AHTF were $146,590.

j) **Emergency Room/Alternate Level of Care**

The Ministry of Health and Long Term Care provided $100,000 in one-time funding to help the LHIN in supporting the North East ER/ALC Performance Lead, this amount was spent in full.

10. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a. The amount repayable to the MOHLTC is made up of the following components:

	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	1,334,539,486	1,334,539,486	-
LHIN operations	4,919,443	4,706,974	212,469
Amortization of capital assets	72,485	72,485	-
E-Health	600,000	600,000	-
E-Health Project Funding	110,000	76,977	33,023
French Language Health Service	209,900	171,738	38,162
Francophone Community Engagement	186,400	118,681	67,719
Réseau du mieux-être francophone du Nord l'Ontario	229,040	229,040	-
Emergency Department Lead	75,000	69,000	6,000
Critical Care Lead	75,000	72,157	2,843
Aboriginal Engagement	100,000	100,000	-
Aboriginal Health Transfer Funding	146,590	146,590	-
Emergency Roon/Alternate Level of Care	100,000	100,000	-
	1,341,363,344	1,341,003,128	360,216

b. The amount due to the MOHLTC is made up of the following components:

	2011	2010
	$	$
Opening balance	296,992	128,332
In-Year funds repayable to MOHLTC	14,500	
Funding recovered by the MOHLTC	(164,902)	-
Funding allowed to be carried into 2011	(146,590)	(45,374)
Funding repayable to the MOHLTC (Note 10A)	360,216	214,034
Closing balance	360,216	296,992

11. Pension agreements

The LHIN makes contributions to the Healthcare of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 35 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2011 was $252,040 (2010 - $222,485) for current service costs and is included as an expense in the statement of financial activities. The last actuarial valuation was completed for the plan as at December 31, 2010. At that time the plan was fully funded.

12. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in the favor of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the *Local Health System Integration Act, 2006* and in accordance with s. 28 of the *Financial Administration Act*.

13. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2016. One of the building leases expire on May 31, 2011 and therefore commitments for this building lease beyond that date are not included below. The LHIN is currently negotiating a lease renewal for this building and it is anticipated the new lease will contain similar terms to the existing lease. Minimum lease payments due in each of the next five years are as follows:

	$
2012	234,780
2013	234,057
2014	224,094
2015	160,786
2016	40,197

The LHIN also has funding commitments to HSPs associated with accountability agreements. As of March 31, 2011 the LHIN had signed Accountability Agreements with all Hospitals and Community Agencies for the next two years. The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from MOHLTC.

14. Comparative Figures

Certain comparative figures have been reclassified to conform to the current year's presentation.